

ANAESTHETISTS IN MANAGEMENT

AIM Secretariat
21 Portland Place
London
W1B 1PY
Tel: 020 7631 8891
Fax: 020 7631 4352
Email: aim@aagbi.org

We are on the web!
www.aimgbi.org

AIM would like to thank Janssen-Cilag and Pfizer Limited for the educational grants, which have assisted us in the publication of this newsletter.

Dear AIM Member

Welcome to the first newsletter from Anaesthetists in Management, the specialist society for those anaesthetists undertaking a management role and for those who are interested in training and education for management in the National Health Service.

In this issue we hope to bring you views of what is happening around the UK, recognising that the health service is evolving differently in England and the devolved countries. There are many changes occurring at the moment – (payment by results, reconfiguration of strategic health authorities, Modernising Medical Careers, practice based commissioning, implementation of the consultant contract, Independent Sector Treatment Centres - to name but a few) all of which contribute to the feeling that we are working in a world which is reactive rather than proactive in the planning and delivery of services. Effective leadership of our speciality, both locally and nationally, will be the key to facing these and many other challenges on a daily basis.

Melanie Jones
Chair, AIM

Inside this issue:	
Management competencies for SpR	2
Memoirs of a Clinical Director	3
Develop the SAS to manage your department	4
Modernising Medical Careers	5
ISTC's—coming to a town near you	6
News from Wales	7
From Business case to regional review— influencing the future of chronic pain services in Northern Ireland	8



AIM Annual conference 2006 – Preliminary notification

This year's conference will be held at the Royal College of Anaesthetists on Thursday November 16th 2006. Put the date in your diaries now. You will receive more details in the coming weeks.



Management Competencies for SpR 3/4/5

In 2005, the demonstration of management competencies became a requirement for all Specialist Registrars in Anaesthesia. The portfolio presented at the RITA must contain documentation which shows how the SpR is able to demonstrate an awareness and experience of management issues. Many deaneries now run generic management courses for all SpRs in their region, some schools of anaesthesia arrange study days to address this learning need and, of course, the long standing Management for Anaesthetists course at Keele University continues to attract delegates. It is recognised that not all SpRs are able to attend these courses due to time and study leave constraints and also that the courses being theoretical do not give the opportunity to undertake management tasks locally.

contributes the clinical insight to a business case? Get the trainee to attend your clinical governance meeting, identify a topic resulting from a risk or complaint and ask them to develop a solution. Do you include an SpR as an observer on appointment committees?



In 2005, the demonstration of management competencies became a requirement for all Specialist Registrars in Anaesthesia.

AIM has suggested activities which can be undertaken locally, enabling the SpR to become involved in management issues of their anaesthetic department.

In response to this AIM have produced "A Statement on Management Skills for Trainee Anaesthetists" which suggests many ways in which a SpR may gain experience of management topics whilst in work, and identifies methods by which they may develop their skills in non-clinical areas. We have suggested activities which can be undertaken locally enabling the SpR to become involved in management issues of their anaesthetic department. These activities will also be of assistance to lead clinicians and clinical directors who have the opportunity to include trainees in the running of the service. It is envisaged that a formal management module could be introduced in most, if not all, anaesthetic and critical care departments.

For full details of how to develop this component of training visit the AIM website at www.aimgbi.org and follow the links for members to information and resources.

*Melanie Jones
Chair AIM.*

If you think this will be impossible, make a list of all the committees you and your consultant colleagues attend, invite a trainee to help you prepare for the meeting and accompany you. Talk to the trainees about your management roles – all consultants are managers (some are just too shy to admit it!!). Can a trainee shadow your directorate manager for the day? Can a SpR be a theatre manager for the day? How is an equipment list for your department prepared? Who

Memoirs of a new Clinical Director

Suspicious were raised when I had to declare my CD interview date to the family over dinner.

“What’s in it for us?” from my wife and eldest daughter in unison at the other end of the table. This was not going to be easy.

I mumbled incoherently about challenges facing the department, career progress (that one did not go down well), it wouldn’t be that much work (went down even worse), more money (eldest daughter brightened at this with university looming) and that I really fancied it. I rode the storm.

A month later I had my interview. A story in itself but to protect the individuals concerned I won’t go into the details of the hour plus process. Baden Powell got it right in his quote¹.

And now in post for 3 months, 22 days and 10 hours what are my thoughts? Well, I’ll be glad when job planning is over, 15 Consultants down and 41 to go by April. Definitely glad that I took the DM’s (Directorate Manager) advice, she has done this once before with the previous CD, to allocate 1.5 hours per Consultant.

Having been a Consultant for 13 years, no big surprises with the amount of work involved. Generally easier than being Programme Director of a School with over 120 trainees, (my previous post), now I only manage 55 Consultants and 60 Trainees, but at least it’s all in my own Trust and they’re all local problems.

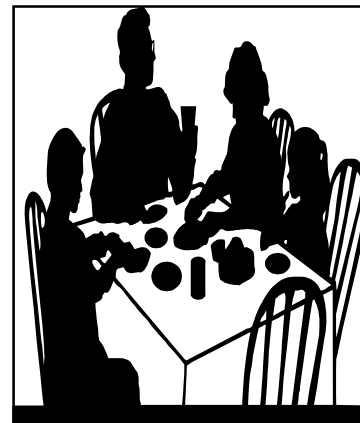
At the expense of sounding like an Oscar winner, one has to acknowledge the support of my DM, the departmental secretaries, service organisers, College tutors and clinical leads. There is no way a CD can do everything, so I don’t try. And you can’t please everyone, so I don’t do that either. The only thing I try to be is consistent and transparent in the process of managing a directorate. I inherited a decent department from the previous CD though.

Management jargon busting is a steep learning curve but there are various useful texts available to handle the phraseology. Don’t however use with non-managerial colleagues since it either creates an anaphylactic reaction of anti-management abuse or their eyes cloud over with non-interest. Use your common sense.

Oh yes, learn to say no and only do things that you enjoy doing.

I Not the famous one about Be Prepared...a scout must prepare himself by previously thinking out and practising how to act on any accident or emergency so that he is never taken by surprise – rather the one that says a Scout smiles and whistles under all circumstances.

*Tony Turley
Clinical Director
Anaesthetic Services
Cardiff*



“What’s in it for us?” from my wife and eldest daughter in unison at the other end of the table. This was not going to be easy.

AIM Trainee Essay Prize

The title of the AIM 2006 Trainee Essay Competition is

“10 Management Competencies I will need as a consultant (and why)”.

No more than 1000 words should be submitted to Busola Oguntula, Specialist Societies Coordinator, AIM, 21 Portland Place, London, W1B 1PY by **September 30th 2006**.

The winner will be invited to present their essay at the AIM annual conference in late 2006 and receive a prize of £250.

Please bring this to the attention of all trainees.

Develop the SAS to help manage your department.



There are several ways that an SAS doctor can contribute in a creative way to the department and the trust and make the job worthwhile and exciting.

The best starting point will be to draw a Personal Development Plan (PDP) and discuss this at the appraisal. The annual job plan review with a mentor or clinical director should identify what one could do and achieve for the following year and the future. Some of the ideas mentioned below are worth considering.

Teaching: Attend the 'Teaching Course' organised by the RCOA or the course held by the local deanery and get the certificate to teach. Then discuss with the 'College Tutor' and get involved in teaching undergraduates, trainees in the department and the anaesthetic staff in operating theatres. Prepare a few 'power point' presentations on subjects of particular interest to you and update them periodically.

Clinical audit: Choose a topic that will probably improve the quality of care and perhaps saves money for the department and the trust. The best guide to choose your topic is to look at the recipes suggested by the RCOA. Explore the possibilities with the audit department and seek guidance from them and the lead clinician in your department.

Try and develop interest in a sub-speciality of your liking which you enjoy and are good at. Make sure that one of the consultants is familiar with it and that it is possible to practise in the hospital. Regional blocks, anaesthesia for speciality surgery, TIVA, acute or chronic pain, obstetrics or ITU are just to mention a few. Join the concerned specialist society, attend courses to learn the necessary skills and obtain the recognised qualification.

Writing: Start off writing your opinion on the articles you read in a journal, describe any interesting experiences you had in the hospital or even write

some protocols and guidelines for procedures and patient information leaflets for your hospital. They are very much appreciated. It is thrilling to see your article in a journal but be prepared to face a few rejections in the beginning. You will eventually find the knack.

Medico-politics: Start off as a representative for your group, get into LNC or get involved with BMA, AAGBI or RCOA. It helps you to network with other colleagues in the country. There is no point in keeping your opinion to yourself.

There is so much to do, if only you look around. Get involved, otherwise the job can easily be monotonous and uninteresting if you just gave anaesthetics and do nothing else.

*Ramana Alladi,
Chair SAS Committee
AAGBI*



**Try and develop
interest in a
sub-speciality of your
liking which you enjoy
and are good at**



MODERNISING MEDICAL CAREERS

In 2002 the CMO published "Unfinished Business" which described the two year Foundation Programme; the first year equating to the current PRHO year and leading to full registration and the second year aiming to ensure all trainees achieve the basic practical skills and competencies in medicine. 2004 saw the publication of "Modernising Medical Careers – the Next Steps" which clarified the programme structure and content.



The Next Steps emphasises the diagnosis and management of the acutely ill patient as the key aim of the new programme, both in the hospital, mental health and general practice settings. Clinical governance, patient safety, infection control, team-working and the patient experience are the five lynchpins for high quality medical care

The GMC remains the accreditation body for the first year of the Foundation Programme (F1) and PMETB will be responsible for the accreditation of the second year (F2). Effective career planning and career support is an integral part of MMC. Trainees are expected to be pro-active in planning their careers when choosing their F2 programmes, audit projects and research.

The first pilot F2 programmes were established in 2004, the number of available programmes increased widely for August 2005 and by August 2006 all of the 2005 graduates will be expected to undertake an F2 programme. The deaneries will have completed the creation of Foundation Schools. A surplus of F2 programmes will be available for non-UK graduates on a competitive basis. A nation-wide matching scheme is planned and has already been piloted.

Anaesthetics, critical/intensive care are considered to be excellent modules for the F2 programmes. It is easy to see why when you consider that F1 trainees are expected to become competent in the following; venepuncture and IV

Canulation, arterial puncture in the adult, injections and IV infusions, to perform and interpret an ECG, to perform and interpret spirometry and peak flow, and airway care amongst others and F2 trainees add the insertion of CVP lines to that list of competencies.

The challenge for medical managers is to ensure that these trainees achieve these competencies and the necessary supervision and teaching is made available within a busy department.

These F2 trainees will not be able to be part of the on-call team without total supervision. However the programme offers an excellent opportunity to attract the best trainees into the specialty and also to create a new cohort of trainees with enhanced competencies in the recognition and treatment of the acutely ill patient which could reduce the workload of a department by more timely treatment and the more efficient use of high dependency and intensive care.

August 2007 sees the next step in the process with the onset of "run-through" training whereby trainees compete for specialty training from the F2 year and, if successful, will progress through to CCT with no further interviews. Transitional arrangements are being made known for those trainees who are already in SHO posts to allow them the same access to compete for these new training programmes. One of the biggest tasks facing Anaesthesia will be dealing

One of the biggest tasks facing Anaesthesia will be dealing with the reduction in the number of SHO posts currently available to meet the needs of "run-through training"

with the reduction in the number of SHO posts currently available to meet the needs of "run-through training" and yet continue to meet the service needs. The MMC website gives information and a flow diagram on the proposed staffing establishment and all clinical directors/programme directors are advised to keep abreast of the information made available on that site.

*Barbara Thornley,
Associate Postgraduate Dean, Oxford.*

ISTCs-COMING TO A TOWN NEAR YOU.

The arrival of competitive market forces is not as welcome in one's own workplace as in a place where you are the customer. Big parastatals* like Royal Mail, energy providers and transport have all recently seen the removal of regulations which maintained some sort of monopoly. It is now the turn of the NHS and the sense of threat caused by its arrival is significant. Although private health provision has existed since the emergence of the NHS, the fact that the same clinicians work for both services has led to the conclusion that true competitiveness does not exist.

About 30 independent sector treatment centres now exist across the UK. These 'first wave' centres are staffed by people recruited from abroad or ex NHS staff who have not been in the NHS for six months. The onus not to deplete the NHS of staff was placed on the organisations at the time that they negotiated for contracts. Some evidence exists that loopholes to this condition have been exploited and health care workers have moved directly from state employ to ISTCs. However, the second wave of ISTCs will be subject to modified restrictions and it is likely that consultants will be able to offer their services to the independent sector in various ways.

Indeed, even now, they may be seconded by the Trust for which they work to provide service for patients transferred from the NHS to the ISTCs.

Present law requires that where this occurs, the consultant will be automatically transferred to the employ of the ISTC. This could lead to the loss of NHS employment privileges such as final salary scheme and the security. A new model of retaining employment within the NHS, whilst on secondment to the private sector, has been developed and anyone who is in such a position is advised to seek legal advice.

Apart from secondment, the emergence of other employers in the healthcare market has provided consultants with other avenues to explore. The speciality of anaesthesia is ideally positioned to form groups which tender to provide services. Chambers, partnerships and

limited liability companies are potential models and, where treatment centres are close to existing places of work, this can provide an easy additional source of income. Initially consultants are likely to retain a substantial percentage of their employment with the NHS but it could be envisaged that this will gradually change and some might elect full time employment with a health management organisation. This raises the spectre of quality assurance issues when there are multiple healthcare providers. Furthermore the American experience of the advent of health management organisations, which heralded the first salaried doctors, led to a rift in the medical community and in a perverse reversal the first doctors in the UK who crossover to be employed in the private sector may be seen as breaking ranks.

The routines of providing anaesthesia remain the same but it appears that the certainty surrounding employment is due to change. This means that both opportunities and threats must be faced by clinicians and managers.

** word of South African origin - used to describe those large corporations which are run by the government - a contraction of parallel+state.*

*Ed Dichmont,
AIM Honorary Secretary*



“Apart from secondment, the emergence of other employers in the healthcare market has provided consultants with other avenues to explore.”

News from Wales

Over the past year we have seen the appointment of Dr Brian Gibbons as the Minister for Health and Social Services and more recently a new Chief Medical Officer has been appointed. This new team at the helm will be striving to implement "Designed for Life" the 10 year blue print for health and social services in Wales produced in 2005. This document recognises that the way services are delivered will need to change to meet changing clinical practice and the demands of external legislation such as the European Working Time Directive – not every hospital in Wales will be able to continue to deliver all their current services.

Waiting times in Wales remain

considerably longer than in England and planning is underway to reach a maximum waiting time from diagnosis to treatment of 26 weeks, by 2009. The Wales Assembly Government has shown no enthusiasm for the concept of involving the Independent Sector in developing treatment centres.



The Wales Consultant Contract has thrown out many challenges to both consultants and their clinical directors,

a proportion of consultants have still to agree a job plan under the terms of the amended contract which was introduced in December 2003. This led, in 2005, to BMA Cymru passing a vote of No Confidence in the Assembly to deliver the amended consultant contract in Wales. Many senior (older) consultants are already receiving commitment awards, which soon all consultants will receive every 3 years subject to satisfactory appraisal (the consultants having voted to dispense with locally awarded discretionary points). For more information visit www.wales.nhs.uk the HOWIS (Health of Wales Information Service) website.

Melanie Jones
Chair AIM

AIM WEBSITE

The AIM website www.aimgbi.org has been running for 2 years now and is still available to all who have internet access. We originally planned to have a hidden "Members' only" section, but have chosen instead to keep the facility completely open-access so that all could benefit from information of interest and value to all anaesthetists who are involved, or likely to become involved, in management. We hope this maintains AIM's profile and attracts interest in, and membership of, AIM.

There are a number of useful links to colleges, societies, government information and other agencies, and we are constantly seeking new links that members and other users would like to suggest. Many

recent AIM presentations are also available. AIM membership forms can be downloaded. A list of recent and forthcoming medical management events is always available, whether run by AIM or not.

Visit our Website:
www.aimgbi.org

Send articles or suggested topics for inclusion in the newsletter to aim@aagbi.org

The webmaster is currently planning to revamp the front page, and make access to the different links and resources easier. Any suggestions are welcome and can be submitted to aim@aagbi.org

Bill Rawlinson
AIM Committee Member
Former Clinical and Medical Director

SUDOKU PUZZLE

For all addicts and as suggested by the trainee member of our committee! (As 'managers' we could not resist 'changing' it a little!

In our version the letters A to I replace the numbers 1 to 9)

Each letter A-I should appear only once in each row, column, and block of nine small squares.

Solution in the next edition of our newsletter.

G			I					
	H	B						C
		A		D	C	F		
					G	B	D	I
							A	F
					I			
H			A			C		D
C						I		
E	A	I			F	G	H	

From Business Case to Regional Review – Influencing the Future of Chronic Pain Services in Northern Ireland

As a clinician it often seems impossible to wield influence within the National Health Service. Too often there seem to be competing priorities for service development and, unless the time and the environment are right, many innovations never progress beyond the 'Business Case'.

Musgrave Park Hospital is the Regional Elective Orthopaedic Hospital in Northern Ireland. In 2003, as Clinical Director of the Orthopaedic Directorate, I met with the Directors of Public Health of our four Area Health Boards to present the business cases for a number of service developments in orthopaedics. One of these was the case for development of my own chronic pain service. There were expressions of interest, but all those present felt that the main barrier to investment in pain clinics was the lack of robust advice on commissioning such services. They needed direction from the Department of Health, Social Services and Public Safety.

Armed with this information, I organised an extraordinary meeting of the Northern Ireland Pain Society to solicit the ideas of all the professional groups involved, put together a discussion paper, approached the Chairman of the Anaesthetics Advisory Committee of the Department and requested that 'The future of adult chronic pain services in Northern Ireland' be discussed at their next meeting.

The Department was interested, and at a second workshop, gathered the views of clinicians and managers for Hospital and Community trusts, Health Councils and general practitioners.

The outcome – a Province-wide review of all chronic pain services for adults, a commitment to improve education in pain management for all clinicians (including the development of a multi-professional MSc in Pain



Management at The Queen's University of Belfast) and an undertaking by the CREST (Clinical Resource Efficiency Support Team, Northern Ireland's NICE) to review the standards for pain services and to develop referral guidelines.

All of the above are now underway and the next challenge will be to keep the work on track during the major redesign of healthcare delivery occasioned by the recent Review of Public Administration.

So seize the day! Use your influence! Engage the interest of those who make things happen! Above all, commit to seeing it through.

Pamela Bell
AiM Committee Member

There were expressions of interest, but all those present felt that the main barrier to investment in pain clinics was the lack of robust advice on commissioning such services